

# Quality Assessment

Report of Major Findings  
Revised 12/14/06

Rhode Island Department of Mental Health, Retardation and Hospitals  
December, 2006

# MHRH Quality Assessment

## Summary of Findings November 2006

### Components of the MHRH Quality Assessment

#### Phase I: History and Quality Assessment

#### Phase II: Organize for Action and Master Plan

#### Phase III: Implement and Evaluate

Phase I of the **MHRH Quality Assessment** was completed in October, 2006. Over the course of the previous three months, the Quality Assessment team met with staff from MHRH, people receiving services/supports, families, community partners, and other stakeholders in order to listen and seek their feedback about the service system. Consistent themes have emerged across the three divisions, as well as important issues unique to each division, which present both challenges and opportunities for the department.

### Summary of Major Themes:

#### **Eleanor Slater Hospital (ESH)**

- Limited movement of patients from ESH to lesser intensive levels of care results in waiting lists of patients receiving long term medical care and psychiatric care in community hospitals

#### **Behavioral Health (BH)**

- Lack of sufficient resources to develop and fund less intensive levels of community-based care results in an increasing, significant use of inpatient hospital services

#### **Developmental Disabilities (DD)**

- Inadequate capacity to transition group home residents to less restrictive, more independent living arrangements, such as supported living arrangements, supervised apartments, etc.

#### **Clarity**

- The mission, direction, priorities, and services MHRH provides needs to be clarified for MHRH staff and community stakeholders

#### **Communication**

- Is lacking within the department as well as between the department and external entities

## Continuum of Care

- The system of care and supports for MHRH's population does not adequately promote independence, choice, and self reliance.
- Care and supports are not always provided in the least restrictive setting. Care and supports for many clients is provided in institutional settings, such as community hospitals.
- Eleanor Slater Hospital patients could be provided care in less intensive settings such as community based therapeutic residential settings, or nursing
- DD group home residents could be provided care in less intensive settings such as independent living arrangements such as cooperative housing
- Excessive reliance on high intensity, more restrictive settings, limiting choice, self reliance, independence and recovery

## Fragmentation

- Fragmented system of care, which needs coordination and integration for individuals with co-occurring disorders such as development disorders, mental illness, medical needs, personal care support needs

## Resources

- Not aligned to prevention, early intervention or community-based treatment

## Focus

- Current system is agency/service focused, not population/individual focused
- Services and supports needed by MHRH's populations are provided and directed by numerous systems, are not well coordinated. There is a need for coordination and integration of services for each client, including:
  - *Housing supports*
  - *Health care, including physical, mental and oral health*
  - *Criminal justice system*

## Lifelong Planning

- There is the need for a smoother transition from childhood to adulthood in the Mental Health (MH) and Developmental Disabilities (DD) service systems
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In Phase II of the Quality Assessment planning process three standing community partnership committees will be formed to establish a **Director's Partnership Council** to look at **quality improvement, consumer services and innovation**. A facilitator for each committee will establish a meeting schedule, and post the schedule on the internet, in e-mails and make the meeting dates known in other ways to the MHRH community. Membership will be open and fluid, so that everyone who wishes can participate.

# Section I:

## Letters to Stakeholders



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Mental Health, Retardation and Hospitals  
OFFICE OF THE DIRECTOR  
14 Harrington Road  
Cranston, RI 02920-3080  
TEL: (401) 462-3201  
FAX: (401) 462-3204

September 28, 2006

Dear Friends and Colleagues,

I would like to invite you to an open community meeting on Thursday, October 12<sup>th</sup> from 2:00 - 4:00 pm at the Ray Conference Center at Butler Hospital.

Shortly after becoming Director of MHRH, I announced a MHRH Quality Assessment to be completed by early October. Over the month of September, the Quality Assessment team has been meeting with clients, community partners, staff and other stakeholders in order to listen and seek input from a wide audience. All input and comments about the department are being gladly received and will be included in the Quality Assessment Findings. Already consistent themes are emerging across the three divisions, as well as important issues unique to each division, which present both challenges and opportunities for the department going forward. We are still refining and adding to the findings, and will continue to receive input.

Let me assure you that this will certainly not be a last opportunity to provide input and be heard by the department. Going forward, the department will be committed to a culture and practice of continuous quality improvement. We will continue to seek and welcome ideas, suggestions, and criticism. The department will foster a culture of continuous improvements and corrections to assure access and quality of care, and appropriate, timely supports for our clients.

I hope you will join me at the community meeting on October 12<sup>th</sup>, where I will present the overall findings of the department's Quality Assessment. As well, I will discuss opportunities I see for the department going forward.

For your convenience, I have attached directions. I look forward to seeing you there or at other opportunities in the future.

My Best,

Ellen Nelson, Ph.D.  
Director



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August 27, 2006

Dear Friends and Colleagues,

I am pleased to announce that the **MHRH Quality Assessment** is underway! The purpose of this very important undertaking is to identify, clarify and understand where MHRH has been, where we are currently, and where we should direct ourselves in the future to best fulfill our mission to provide services and supports to individuals with disabilities. The assessment process has been designed to answer a number of questions such as:

1. *What are the major historical influences on our service system?*
2. *What services does MHRH currently provide?*
3. *For whom?*
4. *Who provides the service?*
5. *Where do the funds come from? How much does it cost? Do other revenue sources exist?*
6. *How do the services of MHRH compare to services provided in other states?*
7. *How can we maximize the use of our facilities, as well as our staff, to most efficiently provide patient care and administer the department's programs?*
8. *Are the services provided by MHRH on the cutting edge? Could we do it better?*
9. *Are there needed services that are not being provided?*
10. *Is the population served by MHRH and their service needs changing?*
11. *How can we maximize our resources to meet the needs of individuals with disabilities for the future?*

The Department of MHRH, and the critical services it provides for thousands of Rhode Islanders, will be clearly described, and a comprehensive plan established to meet the future needs of Rhode Island's most vulnerable citizens.

**Phase I** is underway to gather information and data from within the department, and will be complete by early September. In this Phase, we are concentrating on answering questions 1 through 7 above.

**Phase II** will begin in September. We will share the results of Phase I and seek input from MHRH community partners, staff and other stakeholders. During this phase, information gathered in Phase I will be used to address questions 8 through 11 above. The result of Phase II will be the design of a framework and implementation plan for the future of the Department. We plan to complete Phase II in early October.

We have assembled a team composed of internal MHRH staff, as well as outside, experienced consultants to conduct the quality assessment. The team has formed three workgroups which are looking at each of the three divisions of the department using a similar process. The Quality Assessment Team Members and their role on the team are as follows:

Quality Assessment Team Leader                      Tricia Leddy

Behavioral Health Workgroup

- Charles Maynard
- Ron Tremper
- Carol Burton

Developmental Disabilities Workgroup:

- Christiane Petrin Lambert
- Maya Colantuono
- Camille Letourneau

Eleanor Slater Hospital Workgroup

- Bill White
- Joe Lapenta
- Lou Pugliese

As MHRH implements the plan going forward, there will be a method in place to evaluate the impact of any changes on the access and quality of care and supports, as well as on the health status of the individuals served by MHRH. I plan to create several community task forces and advisory groups, which will provide input to the Department on the impact of changes on the populations served by the department. MHRH is committed to provide continuous opportunities to improve, revise and enhance the plan going forward.

Admittedly, this is an ambitious timetable. However, I am confident that by working together diligently, we can set the course for a strong future, focused on how we can best serve individuals with disabilities in RI. I look forward to sharing the information gathered in Phase I with you and seeking your advice and input as we plan for the best future for MHRH.

Thank you for your contribution in serving individuals with disabilities in Rhode Island. I look forward to working together to design a plan to most effectively serve this population for the future.

For more information on the quality assessment process, you may contact Tricia Leddy, Chief of Staff, at [tleddy@mhrh.ri.gov](mailto:tleddy@mhrh.ri.gov) or 462-3201.

My Best,



Ellen Nelson, Ph.D.  
Director

## Section II:

# History of the Department



## ***History of the Rhode Island Department of Mental Health, Retardation and Hospitals***

### In the early years. . .

- From colonial times, local cities and towns were responsible for the care of the poor, including persons with mental illness, mental retardation, persons who were blind, or deaf or aged. Overseers of the poor in each community made accommodations for their care through an agreement with a neighbor, or with a contract to the lowest bidder.
- The first almshouse was established in Newport in 1723. More “asylums” were established throughout the state, and by 1850 there were 15, most of which were located on so-called “poor farms.”
- In 1850, Governor Henry Anthony, through a resolution of the General Assembly, appointed a commissioner to study the condition of “pauper and insane persons.” Thomas Hazard of Newport was appointed to survey the cities and towns. Overall, he found the care adequate, but criticized the monotony of life in most almshouses, and found the one in Coventry to be of “deplorable condition.”
- In 1864, another commissioner was appointed to monitor almshouses and other ways that the poor were treated. George Willard’s report together with Hazard’s led to the establishment in 1867 of a committee that concluded that state supervision of care of the poor was needed. It also found that towns needed protection from the poor who had no “settlement.” A man and his descendants were considered settled in a community if he owned property and paid taxes.
- In 1869, the General Assembly established a Board of State Charities and Corrections. At the same time, the legislature commissioned the purchase of the William A. Howard farm in Cranston for the establishment of a State Asylum for the Insane Poor and a State Workhouse and House of Corrections. The establishment of a State Almshouse was also authorized, but priority was given to the other two buildings. Completed in January of 1874, the Workhouse building was remodeled and opened as the Almshouse in August of that year to receive the state’s paupers.
- The State’s Almshouse was immediately crowded, as cities and towns sent to Howard unwed mothers, handicapped people, and aged men and women who had no legal settlement. The elderly dominated the growing population.
- In 1879, the state board again called attention to the many sick and “feeble” persons among the 240 Almshouse inmates, and called for the construction of a hospital. In 1880, a 14-bed building was constructed to serve as a hospital. By 1886, the entire Almshouse was regarded more as a hospital than a poor house.

- In 1888, money was appropriated for a more permanent Almshouse building. The complex was erected over a three -year period of stone found on the farm, facing Pontiac Avenue. It accommodated 150 men, 150 women and 60 children. (The building was vacated in the late 1970s, and remained empty until the Department of Labor renovated it and moved its offices there in 2000).
- In 1896, two new buildings were constructed, each to house 20 beds for tuberculosis patients. By 1904, Almshouse Superintendent James Eastman noted that the facility was very overcrowded. The death rate at the Almshouse was extraordinarily high. For example, in 1906, the average daily census was 512. That year, 192 residents died, many being buried on the grounds of the State Farm.

#### In the early 1900s. . .

- In 1905, the Rhode Island State Sanatorium (later the Dr. U. E. Zambarano Hospital), located on Wallum Lake in Burrillville, opened its doors to serve persons with tuberculosis.
- In 1917, the Penal and Charitable Commission was established which assumed responsibility for the Howard facilities as well as the State Home and School (later the Children's Center) in Providence, and the Exeter School for the Feeble-Minded (Ladd Center). Also in 1917 the State Almshouse became the State Infirmary. In 1923, a hospital for women inmates was erected, later known as D ward. Also that year, passage of the Mother's Aid Law (later Aid to Dependent Children) removed widowed mothers of small children from the legal classification of paupers, and enabled them to remain at home.
- In 1923, the Penal Commission was replaced with a new State Public Welfare Commission, later the Department of Public Welfare. In 1935, it was reorganized to become the Department of Social Welfare, creating the largest state bureaucracy with the biggest state budget and the greatest number of employees ever. By this time, 35 buildings to care for the state's needy were at the Howard Complex.

#### In the 1930s. . .

- In 1935, all inmates considered "feeble-minded" were transferred to Exeter. Also in 1935, Governor Theodore Francis Green called for a special referendum to secure voter approval of a list of projects to be built with federal Works Progress Administration monies. Between 1935 and 1937, 20 buildings were erected for the State Hospital for Mental Diseases and four for the State Infirmary. The Infirmary buildings included the "H" building (later named the Dr. Johannes Virks Building); the "I" building (later named the Sister Bernadette Building); an employee dormitory and the laundry building.
- In 1935, the Old Age Assistance Act provided support for persons over 65, helping to keep them out of the "poor house."
- In 1936, there were still 15 poor farms operating in Rhode Island in addition to the state facilities at Howard.

#### In the 1940s. . .

- In 1940, Rhode Island became the first state in the nation to abolish settlement laws. Also that year, legislation was passed for the state to reimburse local communities for the care of the poor. This continued until the last local poor house was closed in Richmond in 1958.
- In 1942, the Rhode Island General Public Assistance Act eliminated all residence and citizenship requirements for aid.

#### In the 1950s. . .

- WWII exacerbated the understaffing at the Infirmary and the State Hospital for Mental Diseases. A 1950 report by a study commission noted the poor conditions at the hospitals, prompting labor leaders Manuel Mathias and James Dolan to successfully pressure for new positions and a reduction in the workweek.
- With the advent of antibiotics in the 1950s, tuberculosis no longer was the threat that it had been for so many decades. The current mission of the Zambarano Hospital in Burrillville began to evolve.
- In 1950, the State Hospital had a capacity for 2700 patients, yet the census was 3200. Many of the patients were not mentally ill, but merely old and confused. The Infirmary refused to accept them. In 1954, Governor Dennis Roberts and Welfare Director Edward Reidy successfully pressed for a bond issue, which later passed, to construct a female geriatric building, which was completed in 1956, and another for men in 1958.
- In 1951, the Parents Council for Retarded Children was formed, and for the next several decades, worked to increase opportunities for their children with developmental disabilities. In 1952, the Council voted to become affiliated with the national Association of Retarded Children.
- Throughout the 1950s and 1960, options for parents of children with developmental disabilities were few. Institutionalization was usually the recommendation of professionals. For most, that meant sending their children to the Ladd School in Exeter.

#### In the 1960s. . .

- In 1960, Governor John Notte formulated a plan to place both hospitals under one superintendent, creating a “Medical Center”.
- In Rhode Island, the federal legislation had been preceded by the passage of the Slater-Chafee Act of 1962. The act provided matching funds for local communities for public education and outpatient services.
- In 1962, the names of the facilities were changed to the Institute of Mental Health and the General Hospital. According to the Department of Social Welfare report of that year, the

eight units of the IMH were responsible for conducting outpatient follow-up clinics, and services for alcoholics were centralized for the first time. A geriatric admission service was established at the General Hospital. The two facilities received their first JCAHO accreditation in 1963.

- Both the General Hospital and the Zambarano Hospital provided long term care for persons with a variety of chronic diseases and conditions; spinal cord injuries; in need of respirators; and other specialized medical attention.
- In 1962, various advocacy groups affiliated as a state organization, called the Rhode Island Association for Retarded Citizens. J. Arthur Trudeau was a prominent, active member of the group. The Association provided activities for persons with disabilities, and advocated for funding and resources to broaden their opportunities. Trudeau worked closely with his long-time friend, Congressman John E. Fogarty, who wrote and championed the “Mental Retardation Facilities and Community Mental Health Centers Act”, passed by Congress in 1963. With its passage, local RIARC chapters provided more opportunities in the community, and advocated for educational and other services for the developmentally disabled. Still, the Ladd Center in Exeter flourished with individuals who spent a lifetime at the institution, due to a lack of training in medical school of doctors, gross misunderstanding of the various disabling conditions, and the stigma of having a developmentally disabled member of the family.
- Over the next two decades, several bond issues were overwhelmingly passed by the citizens of Rhode Island that helped RIARC chapters provide work-skills, recreational and other programs to support community living and increased independence.
- The “Mental Retardation Facilities and Community Mental Health Centers Act”, written and championed by RI Congressman John Fogarty, was passed by Congress in 1963. This had a profound affect on mental health services in the state, by providing funds for the development of eight community mental health centers located in catchment areas throughout Rhode Island.
- In 1966, the IMH had a 2100-bed capacity. Nine hundred psychiatric patients were transferred to the General Hospital, which inherited the Louis Pasteur Building the Benjamin Rush Building, and two buildings named for labor leader Manuel Mathias and Representative James Varley, chairman of the House Welfare Committee that worked to improve conditions at Howard. In that year, the hospital reported 1726 beds.
- Throughout the 1960s, clinical, social and other services and programs were modified, eliminated or added to provide care for the changing populations served at the hospitals.
- In 1967, the Office of Mental Retardation was established within the Department of Social Welfare. Later, it was encompassed into the Department of Mental Health, Retardation and Hospitals.

#### In the 1970s. . .

- Under Governor Frank Licht, the Department of Social Welfare was broken into separate agencies: in 1970, the Department of Mental Health, Retardation and Hospitals was established; the Department of Corrections was established in 1972. The Department of Children, Youth and Families was established in 1980.
- In 1970, the Center General Hospital, operated by the Rhode Island Department of Mental Health, Retardation and Hospitals, providing long term care, had an average daily census of 1300 patients. Medicaid stimulated the growth of skilled nursing and intermediate care facilities throughout the state, and the pressure to admit aged people began to decline.
- Throughout the 1970's, through deinstitutionalization, many hospital residents from the General Hospital and Zambarano (as well as patients at the Institute of Mental Health) were discharged to "community settings."
- Throughout the 1970's, The Institute of Mental Health at the Rhode Island Medical Center (later the John O. Pastore Center) in Cranston continued to provide long-term psychiatric services for Rhode Islanders with problems of mental illness.
- The hospital average daily census during the '70s was as high as 1800, and gradually decreased to 600 by 1980.
- By the 1970s, deinstitutionalization of the Ladd Center was in progress, as bond issues passed overwhelmingly for the state to purchase and renovate homes in the community for developmentally disabled citizens.

#### In the 1980s. . .

- With bond issue money, a new medical services building, the John F. Regan Health Care Services Building was constructed in 1981.
- Community services for persons with mental illness expanded throughout the 1980s, to include residential services, employment programs and other opportunities in addition to treatment and counseling. Through "deinstitutionalization" people who did not need hospital level care were treated in the community. The remaining population is best served in a hospital setting.

#### In the 1990s. . .

- In 1994, the Institute of Mental Health was unified with the Center General Hospital and the Zambarano Memorial Hospital to become the Eleanor Slater Hospital. Hospital psychiatric services are provided at the Adult Psychiatric Services Unit, as well as the Psychogeriatric Unit of the hospital. Admissions were streamlined, to include persons in need of long term hospital level care.

- The mission of the Eleanor Slater Hospital today is to provide long-term hospital-level care to people with chronic or debilitating medical and psychiatric illnesses.
- In 1994, the last five residents of the Ladd Center moved into group homes, and the institution closed. Rhode Island became the third state in the nation with no institutional services for persons with developmental disabilities.
- With the passage of the Americans with Disabilities Act, the 1990's became the decade of the individual. Children with disabilities began to be mainstreamed in the classroom.
- MHRH developed a CHOICES waiver, dealing mainly with acute care services, creating a single funding stream, and increasing dramatically the kinds of services available in the community support network. While MHRH withdrew the CHOICES in 1997, many of its key concepts, such as increasing the individual's control over his or her service needs, remain in effect.
- The waiver for long-term services, has been in effect since 1982, and is renewed every five years.

#### In the new millennium. . .

- In 2000, the Division of Substance Abuse was transferred to MHRH from the RI Department of Health. In 2000, mental health services and substance abuse services were combined to form the Division of Behavioral Healthcare.
- "Recovery" standards and policies were incorporated into the framework of the division.
- Supported employment initiatives for persons with developmental disabilities were expanded through a revised Cooperative Agreement between MHRH and DHS.
- For the first time, in 2001, treatment services for problem gamblers were provided with a grant from the RI legislature through the Division of Behavioral Healthcare Services.
- In 2001, the state established the Governor's Council on Behavioral Health to advise the governor and members of the general assembly on policies and goals of the behavioral health programs.
- In 2001, a revitalization of the discharge from at the Eleanor Slater Hospital facilitated the appropriate movement to community settings of patients who no longer required hospital-level care.
- In 2002, a three-year \$9 million federal grant was awarded to the Division of Behavioral Healthcare to develop a comprehensive statewide prevention plan to reduce the use of alcohol, tobacco and other drugs in youth and to fund science-based prevention programs.

Section III:  
Division of Behavioral  
Healthcare Services

## ***History of the Division of Behavioral Healthcare***

This history is slanted to highlight items reflected in the final report for example: 1) the need for continued consolidation of the Mental Health and Substance Abuse operations, 2) a review of the issues caused by the separation of the responsibilities for the adult and children's mental health services, and 3) better collaboration between the Divisions of Behavioral Healthcare Services and Developmental Disabilities, especially around individuals with autism.

When the Department of Mental Health, Retardation and Hospitals was created in the late 1960s, it assumed control of the overall medical center which included Center General Hospital and the Institute of Mental Health.

The Division of Mental Health assumed responsibility for the operation of the IMH which handled both long-term patients and acute admissions. When coupled with the community system which was handled through the Division's Office of Community Mental Health Services, this gave the Division control of funding for the full range of MH services in the state.

The hospital average daily census during the 1970's was as high as 1800, and gradually decreased to 600 by 1980. The "Mental Retardation Facilities and Community Mental Health Centers Act", written and championed by RI Congressman John Fogarty, was passed by Congress in 1963. This had a profound affect on mental health services in the state, by providing funds for the development of eight (8) community mental health centers located in catchment areas throughout Rhode Island.

In the early-70s, the IMH included a basic 'adult hospital' plus specialty units for Psycho-Geriatrics, Multi-Handicapped (MR/MH), Adolescents, and Forensics.

In an effort to both down-size the IMH and provide the higher levels of medical care required by an aging population, the Psycho-Geriatric Unit was transferred to the Division of Hospitals over the period 1973—1975. The Multi-Handicapped Unit was transferred to the Division of Retardation in late 1980—early 1981 in an attempt to consolidate responsibility for individuals with MR as well as to continue downsizing. While this effort succeeded, it also drew an artificial boundary around individuals with co-occurring MR/DD and mental health issues which carry through to the present day.

When the state moved to consolidate the provision of all services to children in a single department, the Adolescent Unit was transferred to DCYF on January 27, 1981 along with its community counterpart, Mental Health Services for Children and Youth, which was operating under the Office of Community Mental Health Services. Unfortunately, the relatively small size of the mental health operations in relation to the overall DCYF, combined with the pressing needs in the area of protective services, resulted in an initial loss of both identity and resources for the mental health function.

Also in the late 1970's and early '80s a series of initiatives were developed to transfer/discharge IMH patients to community based services, beginning with the "Providence Impact Grant". This



was followed by the “IMH Transfer Project” to Community Mental Health Centers, where the “money followed the patient” thus reducing the IMH capacity and expanding the community mental health system.

These transfers were followed by the transfer of the operation of Barry Hall to the Eleanor Slater Hospital in 1990 followed by the transfer of the remainder of the IMH to ESH on 2/25/94. While the latter transfers enabled the State to recoup a significant amount of new Federal Medicaid reimbursement, the bifurcation of responsibility created discord in the overall system.

Originally, Substance Abuse services were under the purview of the Chapin Hospital. Over the next few years, responsibility shifted to a separate unit reporting to the Director of Hospitals and Rehabilitation Services; then to a unit reporting to the Governor’s “Drug Czar”; then to a separate Department of Substance Abuse; then to a Division within the Department of Health.

Finally, in 1998, SA was moved back to the Department of Mental Health, Retardation and Hospitals as a separate Division of Substance Abuse Services.

In 2000, the Department of Mental Health, Retardation and Hospitals began to move towards the creation of a Division of Behavioral Health by consolidating the financial offices of Division of Integrated Mental Health Services and the Division of Substance Abuse Services into a single unit. This was followed relatively quickly by consolidation of the research and data evaluation functions and the creation of an integrated planning unit.

## ***Current Legal and Regulatory Authority***

The Division of Behavioral Healthcare Services encompasses the following services:

1. Substance Abuse Treatment and Prevention Services
2. Integrated Mental Health Services

The purpose of the Substance Abuse Treatment and Prevention Services within the Division of Behavioral Healthcare Services is to provide funding, planning, technical assistance, standards development, and oversight to substance abuse treatment and prevention services, as well as to programs for problem gambling.

The purpose of the Integrated Mental Health Services within the Division of Behavioral Healthcare Services is to fund, plan, develop, implement and oversee a complete and comprehensive system of mental health services. The Department's highest priorities shall be to provide these services to adults with serious mental illness. There shall also be technical assistance provided to all state supported diagnostic facilities, rehab centers, community residences, community mental health centers, and other facilities for adults with serious mental illness licensed by the Department of Mental Health, Retardation and Hospitals.

**It is important to note that these statutory mandates are subject to available appropriations. As such they are mandates to the extent to which we have available appropriated funds from the state legislature to meet our statutory obligations. Our eligibility for the SAPT Block Grant is conditioned upon certain maintenance of efforts requirements and terms and conditions that can only be funded with state dollars (e.g. SYNAR).**

Statutory Authorities:

In addition to the many statutory obligations, powers and duties listed in Rhode Island General Laws §40.1 *et seq.* the following statutes contain specific powers and duties assigned to the Department of Mental Health, Retardation and Hospitals' Division of Behavioral Healthcare Services.

Rhode Island General Laws § 5-69 License Procedure for Chemical Dependency Professionals

Rhode Island General Laws § 16-21.2 Rhode Island Substance Abuse Prevention Act

Rhode Island General Laws § 16-21.3 Rhode Island Student Assistance Junior High/Middle School Act

Rhode Island General Laws § 23-1.10 Alcoholism

Rhode Island General Laws § 23-10.1 Emergency Commitment for Drug Intoxication

Rhode Island General Laws § 31-27-2 Motor Vehicles Offenses (Driving under the influence of liquor or drugs)

Rhode Island General Laws § 3-7-6.1 Retail Licenses (Alcohol Server Training Program Certification)

## *Services Provided*

The following services are provided, to individuals with mental illness and chemical dependency issues in the state of Rhode Island, by Behavioral Healthcare Organizations licensed and / or contract by the Department.

Emergency, Crisis Intervention, and Crisis Stabilization Services  
Medication and Laboratory Services  
General Outpatient Services  
Services for Persons with Co-Occurring Disorders: Mental Health and Substance Use Disorders  
Case Management and Community Psychiatric Supportive Treatment  
Intensive Outpatient Services  
Rhode Island Assertive Community Treatment (RIACT- I)  
Community Integration Programs & Services  
Supported Housing Services  
Residential Services  
Community Support Programs  
Family Psycho education  
Outpatient Detoxification Services  
Medical Detoxification Services  
Opioid Treatment Programs

All services provided to individuals to address the prevention of substance use and other behavioral disorders in the State of Rhode Island, by the Department and by Substance Abuse Prevention Organizations Certified by and/or contracted with the Department, including Student Assistance Programs and coalitions funded through the Rhode Island Substance Abuse Prevention Act, can be grouped into one or more of the following categories:

**Public education/social marketing** includes activities to increase community awareness and change community norms and attitudes;

**Community mobilization and organization** include activities to change statutes, policies and procedures; and

**Change individual, family, and group behaviors and attitudes** include school-based prevention programs, family-oriented programs, socialization programs, and early identification and intervention programs.

### **Rhode Island Substance Abuse Prevention Act (RISAPA) Substance Abuse Prevention Task Forces**

In 1987 the Rhode Island General Assembly passed the Rhode Island Substance Abuse Prevention Act (RISAPA)—RI General Laws 16-21.2—to promote comprehensive prevention programming at the community level. Funding for RISAPA is provided through an annual legislative appropriation administered by MHRH. Thirty-five municipal task forces, covering all

of the state's 39 cities and towns, engage in local needs assessments; and planning, implementation, and evaluation of strategies, policies, and programs to produce long-term reductions in substance use and abuse.

**The following programs are administered by the Department:**

The Community Medication Assistance Program (CMAP) – is a program that provides psychotropic medication free of charge to clients of the community mental health system who cannot afford to pay for it on their own.

Pre-Admission Screening-Resident Review (PASRR) - This program is Federally Mandated and conducted under an Inter-Departmental Agreement with our sister state agency, the Department of Human Services. It requires our Department to review and determine for each applicant to, or resident of, a nursing facility who has mental illness whether they are properly placed and, if so, whether they are receiving appropriate services. The Department has a much stronger "presence" in nursing facilities as a result of this activity and has made significant steps in insuring appropriate care.

Treatment Accountability for Safer Communities (TASC) Unit - This unit provides evaluation, assessment and referral services for substance-using criminal offenders to community-based treatment providers. Referrals of adult and juvenile clients are received from various agencies of the criminal justice system; prospective clients are generally mandated to participate in substance abuse treatment. The case management component of TASC involves treatment monitoring, providing progress reports to agents of the criminal justice system on each client's activity in treatment, and follow-up with clients to ensure their compliance with treatment requirements. The client caseload of the TASC Program includes individuals referred due to Driving Under the Influence (DUI) and Chemical Test Refusal charges, as well as other drug/alcohol-related offenses.

## ***Best Practice Discussion***

### **Integrated Mental Health Services:**

#### Evidence-Based Services:

The Surgeon General's 1999 report on mental health<sup>1</sup> highlighted a selected group of services that have a particularly strong base of evidence for their effectiveness in treating adults with severe mental illness. Following up on this report, SAMHSA began defining and developing 'implementation toolkits' on a selected set of Evidence-Based Practices.

The practices that are currently being implemented in RI are as follows:

Assertive Community Treatment (ACT): ACT is implemented statewide as "RIACT-I" with 15 programs serving an estimated 1,074 clients monthly. The program provides a multi-disciplinary team approach to provide intensive treatment, support and rehabilitation services to individuals with severe and persistent mental illness complicated by factors such as substance abuse, involvement with the criminal justice system, etc. The RI program served as one of the models for the development of the NAMI PACT Manual which serves as the primary measure of fidelity nationwide.

DBH also designed and is implementing a less intensive version of this program (RIACT-II) for individuals who need more than basic community support services but who do not require the intensity of RIACT-I.

Supported Employment: SE is implemented in 8 locations state wide, serving an average of 449 clients per month. The program assists people in obtaining competitive employment in accord with client choices and capabilities without requiring extended training. Fidelity to the national standards as detailed in the PORT study and the IPS model is monitored through biennial site visits.

### **Medication Algorithms:**

The Community Medication Assistance Program provides psychotropic medications for community clients who are unable to afford them. The program emphasizes utilization of new generation atypical anti-psychotics as a first line treatment and insures consistent client care through adherence to APA practice guidelines and recommendations.

### **Integrated Dual Diagnosis Treatment (MI/SA):**

Treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter have been implemented at 2 locations serving approximately 30 clients at any one time.

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<sup>1</sup> (U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999)

### Family Psycho education:

The RI Chapter of NAMI conducts basic programs to provide emotional support, education and problem solving skills to families through the national ‘Family-to-Family’ program. While this program closely approximates the EBP, its lack of a strong clinical component keeps it from being fully compliant with the standard.

### Supported Housing:

Supported housing is a program model in which staff assists clients to obtain and maintain safe, decent and affordable housing in the community through periodic visits from staff for monitoring and/or assisting with residential responsibilities. The program highlights functional separation of housing from clinical service provision right to tenure and an individualized approach. There is currently one program in RI serving approximately 50 clients at any given time working towards full compliance with this model.

### Illness Management/Recovery:

This item encompasses a broad set of rehabilitation methods aimed at teaching individuals with a mental illness methods for collaborating actively in their treatment and developing strategies for managing their illness. There is no Federal fidelity measure currently available for measurement. However, the overall RI system is strongly recovery based and emphasizes client participation in their treatment as evidenced by the requirements of the recent Rules and Regulations as well as Medicaid requirements for active participation in treatment planning.

### **Substance Abuse Prevention Services:**

Prevention and health promotion programming exists within a complex web of influence. In the United States, one of the most significant strands in that web over the past decade has been a move toward an increased emphasis on accountability. This trend has been impacting government<sup>2</sup> and the non-profit worlds alike<sup>3</sup>. It comes under many rubrics, such as “science-based”, “results-based”, “evidence-based” or “outcome-based”, but the themes are the same: agencies and organizations are asked to clearly define not just their activities but also their outcomes.

Fortunately for prevention practitioners, during this same period, federal agencies and private foundations have funded research programs, which have been developing a science of prevention. Prevention science, through multiple studies, has been accumulating information on what works, for whom and for which sort of problems. For example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has identified Science-Based

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<sup>2</sup> United States General Accounting Office. (June 1997). The Government Performance and Results Act: 1997 Government-wide implementation will be uneven (GAO/GGD-97-109), Washington, DC: United States General Accounting Office.

<sup>3</sup> United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America.

model and promising programs; established a process for identifying effective, evidence-based programs and practices; and established a Registry of evidence-based interventions (National Registry of Evidence-based Programs and Practices). The “Principles of Substance Abuse Prevention” have been extracted from results across many prevention programs.<sup>4</sup> Finally, materials have been developed that can assist prevention practitioners in the step by step inclusion of critical elements and making the best use of science-based/evidence-based programs and practices and/or “Principles of Substance Abuse Prevention”.<sup>5</sup>

The Division of Behavioral Healthcare Services is committed to sustaining a prevention system consisting of (1) culturally appropriate science-based programs and best practices, which (2) are organized into comprehensive community-based prevention on the local level and (3) are supported by coordinated funding and technical assistance from the state level. This commitment is reflected in language included in the [Rules & Regulations for the Certification of Substance Abuse Prevention Organizations](#).

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<sup>4</sup> Center for Substance Abuse Prevention (2001). Principles of Substance Abuse Prevention. Washington, DC: Substance Abuse and Mental Health Services Administration.

<sup>5</sup> Wandersman, A., Imm, P., Chinman, M., Kaftarian, S. (1999). [Getting to outcomes: Methods and tools for planning, self-evaluation, and accountability](#). Center for Substance Abuse Prevention: Rockville, MD.

## **Substance Abuse Treatment Services:**

Prevention and health promotion programming exists within a complex web of influence. In the United States, one of the most significant strands in that web over the past decade has been a move toward an increased emphasis on accountability. This trend has been impacting government<sup>6</sup> and the non-profit worlds alike<sup>7</sup>. It comes under many rubrics, such as “science-based”, “results-based”, “evidence-based” or “outcome-based”, but the themes are the same: agencies and organizations are asked to clearly define not just their activities but also their outcomes.

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Evidence-based practice can be defined as an intervention that shows consistent scientific evidence of being related to preferred client outcomes.<sup>10</sup> For providers of substance abuse

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<sup>6</sup> United States General Accounting Office. (June 1997). The Government Performance and Results Act: 1997 Government-wide implementation will be uneven (GAO/GGD-97-109), Washington, DC: United States General Accounting Office.

<sup>7</sup> United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America.

<sup>8</sup> Center for Substance Abuse Prevention (2001). Principles of Substance Abuse Prevention. Washington, DC: Substance Abuse and Mental Health Services Administration.

<sup>9</sup> Wandersman, A., Imm, P., Chinman, M., Kaftarian, S. (1999). Getting to outcomes: Methods and tools for planning, self-evaluation, and accountability. Center for Substance Abuse Prevention: Rockville, MD.

<sup>10</sup> Addiction Technology Transfer Center (2003). Best Practices in Addiction Treatment: A Workshop Facilitator's Guide. Kansas City, MS. ATTC.



treatment, evidence-based practice requires that decisions about treatment are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by knowledge of those providing care, within the context of available resources.<sup>11</sup>

In the past year, the Division of Behavioral Healthcare hosted a committee to assess current adoption of evidence-based practices within the Rhode Island substance abuse treatment system and to make recommendations for improvement. This committee included consumer advocates, treatment providers, representatives of the ATTC-NE, and the DBH. The expectation of DBH for providers to adopt evidence-based practices is reflected throughout the *Rules and Regulations for Licensing of Behavioral Healthcare Organizations*.

Recent licensing/monitoring reviews by the substance abuse treatment unit yielded information on the use of EBPs within Rhode Island's substance abuse treatment network. Reviewers identified examples of cognitive behavioral interventions, community reinforcement, 12-step facilitation, the matrix model, contingency management, and pharmacological therapy.

The Division of Behavioral Healthcare continues to support the implementation of EBPs into the treatment community by providing the necessary clinical training through DATA (the Drug and Alcohol Treatment Association) and the New England Institute of Addiction Studies. DBH provides individual scholarships for individuals to attend the annual School of Best Practices hosted by NEIAS in Waterville Valley, New Hampshire. DBH substance abuse treatment unit staff regularly attends trainings to keep current with BP and are available to provide technical assistance to our providers.

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<sup>11</sup> Dawes et al (2005). Sicily Statement on Evidence-Based Practice. BioMed Central Ltd., Vol.5, Article 1. pp.8.

## ***Initial Findings***

The Division of Behavioral Healthcare Services Quality Assessment Team spent many hours meeting with staff of the Department and members of the stakeholder community including providers, consumers and advocates. The team also conducted a comprehensive review of a wide range of data, reports and resource documents to gain an overall understanding of the system and the climate in which it operates.

In order to present a coherent picture, the team's initial findings are classified into four (4) major categories; systems, services, communications and populations. Each category is listed below along with 2-3 of what the team considered to be the most significant findings from each. This is followed by a complete list of all findings divided by category.

An overall concern expressed throughout the review was the lack of adequate resources to effectively fulfill the Department's mission. This lack was identified both in terms of the availability of staff within the division as well as in money available to the Division to fund services in the community.

Given this concern, it is extremely important to note that the team fully recognizes that some of its findings will have major fiscal and systemic implications. However, given constraints in terms of both time and resources, the team did not make any attempt to quantify these implications.

1. Systems –

Systems issues were found within the Department, between the Department and other state agencies, and between the Department and stakeholders.

Major findings within this category:

- Recommend that the Department clarify the role of the Eleanor Slater Hospital Adult Psychiatric Unit in relationship to the Division of Behavioral Healthcare Services.
- Recommend collaboration with the criminal justice system to ensure appropriate care and treatment for people who are in the criminal justice system and suffer from a mental illness and or substance abuse.
- Recommend that the Department assess its role in the delivery of Behavioral Healthcare Services to children.

2. Services –

By service we mean working to enhance the continuum of care concept and allow services to remain flexible and responsive to meet the needs of a changing population.

Major findings within this category:

- Recommend a strengthening of the integration of the Division of Behavioral Healthcare services for individuals with mental illness and substance abuse.
- Recommend the Department work with the provider communities in enhancing - step down services – to seek the most appropriate and effective approach to the care and treatment of people who need services.
- Recommend that while DBH is already implementing some evidence based services it should conduct a review of the feasibility of additional evidence

based practices and implement those that are appropriate to our system of care.

3. Communication –

We determined that there are intradepartmental communications issues and also communications issues between the Department and other state agencies and stakeholders.

Major findings within this category:

- Recommend that the Department participate when asked for information from the State Budget Office in reference to the Caseload Estimation Conference. When looking at Medicaid – the Rehab Option has not been part of the process. Data is there but it needs to be tied in with the Medicaid claims.
- Review the Department’s organizational structure to determine if it is conducive to effective communications for all staff.
- Staff members of the Department have little to no knowledge of the Department’s relationship to and/or participation with the Secretariat, other state agencies, the Budget Office/Governors Office, providers and advocates.

4. Populations –

There is a definite need to clarify the population the Department is statutorily mandated to serve. In addition to the approximately 46,000 individuals being served, there are what is called emerging populations who are not being adequately served by the present system of care.

Major findings within this category:

- Recommend that the Department continue identify ways to address treatment / service options for the newly emerging populations, three were identified: 1) individuals new to the system with co-occurring disorders who have had some contact with the criminal justice system, 2) people with autism who are now in the DD system and some who have spilled over into the mental health system, 3) young adults with co-occurring disorders.
- Recommend that the Department clarify the population the Department is statutorily mandated to serve.

Following is a complete listing of all findings.

1. **System –**

- Recommend collaboration with the criminal justice system to ensure appropriate care and treatment for people who cross over into the criminal justice system and suffer from a mental illness.
- Recommend that the Department clarify the role of the Eleanor Slater Hospital Adult Psychiatric Unit in relationship to the Division of Behavioral Healthcare Services.
- Recommend that the Department assess Children’s Mental Health Services and where the responsibility lies for the treatment of mentally ill children.
- Recommend working toward a closer collaboration of Division of Developmental Disabilities and Division of Behavioral Healthcare Services.

- Recommend the Department look at prescription drug monitoring programs (Kentucky model), is there a possibility of doing this here in Rhode Island?
- Recommend that the Department move the provider communities toward more integrated care utilizing continued Co-occurring Disorders training.
- Recommend that the Department continue to support cross training community provider staff at the NE School Leadership Institute.
- Recommend that the Department address the log jam for in-patient care – which exist for a number of reasons:
  - greater presence of the CMHC's in the ER's
  - physician's have become more liability conscious
  - greater savvy of the system consumer "catch phrase" knowledge and use
- Recommend that the Department look at a way to break the cycle of pumping the majority of our resources into the CSP population and the bare minimum into the rest of the population.
- Recommend that the Department re-visit the issue of General Outpatient services.
- Recommend that the Department work with DCYF to address: Youth in transition, the definition of a DCYF youth differs from the CSP eligibility criteria requirements making smooth transfers from the DCYF system to the Adult system difficult.
- Recommend that the Department take a serious look at the issue that on the mental health side the majority of the money it is tied up in service provision. Some thought needs to be given to how to free up some of this money to address the issues of prevention and early intervention.
- Recommendation that given the changing demographics of the state should there be some review / re-visiting of the issue of catchment areas. Should or shouldn't we focus more on the locations of the priority populations, put our resources where the need is concentrated most.
- Recommend that the Department take a serious look at whether or not the licensing of Chemical Dependency Professionals appropriately housed within the Department?

## 2. **Services –**

- Recommend a strengthening of the integration of the Division of Behavioral Healthcare services for individuals with mental illness and substance abuse problems.
- Recommend the Department work with the provider communities in enhancing - Step down services – seek the most appropriate yet effective approach to the care and treatment of people who need services.
- Recommend that the Department take a look at housing/residential contracts within the Division of Behavioral Healthcare Services.
- Recommend the Department look at expanding the availability of methadone and adolescent methadone treatment.
- Recommend that the Department take a serious look at Buprenorphine funding and monitoring of these programs so that we can see how this is working within the state and nationally and see if clinical services are working (done through insurance now).
- Recommend that the Department look at the admissions into residential programs. It appears that clients are being admitted to higher levels of care than they need simply

because there is a lack of adequate housing and lower-level support services to allow them to live successfully in the community.

- Recommend that the Department expanded supported employment into outpatient and co-occurring treatment services from its current isolation in CSP level of care.
- Recommend that the Department complete a review of the Mental Health Law and Court Ordered Out-patient Services.
- Recommend that while DBH is already implementing some of the evidence based services, the Quality Assessment Team strongly believes that Rhode Island should conduct a through review of the feasibility of the remaining practices to the Rhode Island system and implement those that are appropriate as quickly as possible.

### 3. **Communication –**

- Recommend that the Department review the focus of public relations and marketing efforts. Creating a way to promote mental health and healthcare while placing an emphasis on the leadership role of the Department in these endeavors to reduce the stigma so long associated with mental health and substance abuse issues.
- Recommend that the Department participate when asked for information from the State Budget Office in reference to the Caseload Estimation Conference. When looking at Medicaid – the Rehab Option has not been part of the process. Data is there but it needs to be tied in with the Medicaid claims.

Our initial analysis also identified potential issues related to relationships and communication within the Department.

Is the Department's organizational structure conducive to intra-agency communications?

- Between Senior Management and Divisions
- Among the Three (3) Divisions
- Among Units within the Divisions

What is the Department's relationship and participation?

- In the Secretariat
- With other state agencies
- With the Budget Office/Governors Office
- With Providers, Advocates and the general public

The point here is how well informed is the staff in understanding the above relationships in order to have a better understanding of the mission of the Department.

### 4. **Population –**

- Recommend that the Department address the unmet mental health treatment needs of the citizens of Rhode Island who are uninsured or underinsured.
- Recommend that the Department continue working hard to identify ways to address treatment / service options for the newly emerging populations, three were identified:

1) individuals new to the system with co-occurring disorders who have had some contact with the criminal justice system, 2) people with autism who are now in the DD system and some who have spilled over into the mental health system, 3) young adults with co-occurring disorders.

- Recommend that the Department seek to re-fund the adult drug court through the Justice System grants family drug court as well.
- Recommend that the Department clarify the population the Department is statutorily mandated to serve.
- Recommendation that the Department collaborate with the Departments of Health and Elderly Affairs regarding the following. There appears to be overlapping areas of responsibility between the Departments of Health and MHRH for the investigation of allegations of abuse, neglect, and mistreatment as well as oversight of quality of care when it comes to dealing with individuals with mental illness who are treated in hospital emergency rooms. Additionally, this becomes even more complicated when the individual is elderly and another sister State Agency, Department of Elderly Affairs, becomes involved.

Section IV:  
Division of Developmental  
Disabilities Services

## *History*

The Department of MHRH, Division of Developmental Disabilities has transitioned from a system of care predominated by a large institutional base, sole service provider, to a service system which is person centered, community-based, dispersed, and focused on providing the necessary supports to promote personal choice and valued membership in the community.

The evolution of services for individuals with developmental disabilities has been paralleled to the civil rights movement. Sociologist Bernard Farber has used the idea of “surplus” populations to describe this kind of fatalistic view of retarded people.

*retarded citizens, like the ill, the disfigured, the aged, the poor, or racial minorities, are perceived as marginal, and therefore expendable people.”*

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People

Institutionalization became the prescription from health care professionals to parents. There were no other options. The Ladd Center was so distant for most families, that once their son or daughter was placed there, they became isolated from society. On a local and national level, institutional life was chronicled and photographed showing the horrible conditions that were forced on many individuals – overcrowding, abuse, inadequate food and shelter, lack of personal property, no privacy, and lack of opportunities to participate in any meaningful activities. Parents wanted another option.

In 1951, the Parents Council for Retarded Citizens was formed. Armed with knowledge gained through a commitment to educate themselves about mental retardation, they advocated for change. In 1952, the Council voted to become affiliated with the national Association of Retarded Children. Local groups were created throughout the state and in 1962 they created a state association, the Rhode Island Association for Retarded Citizens. By 1968, RIARC included ten regional chapters with almost 1,000 family memberships. Arthur Trudeau, a charismatic leader and parent, enlisted the help of Congressman John Fogarty. Mr. Fogarty states in a speech:

*My long-time friend, J. Arthur Trudeau gave me my first real insight into the hell-on-earth that so recently represented existence for mentally retarded children. In 1954, I was asked to address a small organization in Rhode Island composed of the parents of mentally retarded children. I didn't know much about mental deficiency, so I listened more than I talked. I had heard the familiar statistics about there being five million mental defectives in the country and three hundred more born each day to American families, but I had never before looked into the eyes of parents to whom these children had been born. They told me of the hopelessness of the treatment outlook, of the difficulties of getting these children into any kind of school, of the tragic air of rejection and defeatism which seemed to engulf all professional and public discussion of the plight of these children.*

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People



At the national level, in 1963 the President's Panel on Mental Retardation presented a national plan that recommended community-based programs, and a reduction in the number of individuals who lived in institutions. This report, along with champions at the national level such as Congressman John Fogarty, as chairman of the House Appropriations Committee, resulted in a shift in national policy with regard to services for individuals with retardation. Laws such as *Mental Retardation Facilities and Community Mental Health Centers Construction Act*, amendments to the *Vocational Rehabilitation Act*, Mental Retardation Amendments, and changes to the *Social Security Act* resulted in the ability of states to access federal funding to develop community-based programs and services. The Americans with Disabilities Act (ADA) passed in 1990 eliminated many of the barriers that existed in accessing community sites.

*No doubt many of you can recall, as I can, when the retarded child was each family's private – often even its secret – problem. Individually, every parent tried his best to solve the problem. Doctor after doctor was called upon, institution after institution was tried, until at last hope sunk into desperate resignation. There was only one ending to that private, secret road: failure. It has been little more than a decade that a newer way has been tried on a nationwide scale – the way of cooperation, the way of banding together. Instead of the intermittent pushes of an individual parent against the hard wall of prejudice and apathy, there is now the mighty push of millions. And the wall is crumbling.”*

-Congressman John E. Fogarty, 1961

In Rhode Island, Arthur Trudeau and other leaders used their talents to rally the community and raise funds to develop and implement programs and activities for individuals with disabilities in their communities. Through the grassroots action of families, the Office of Mental Retardation was established in Rhode Island law in 1967. Initially vetoed by the Governor, parent advocacy and support from key members in the House and Senate resulted in the veto being overturned.

Other leaders such as Paul Sherlock and Jim Healey galvanized support in the State Legislature resulting in Rhode Island being the first state to enact legislation requiring that all handicapped children are entitled to an education. The concept of a community-based system received significant support from Rhode Island citizens, through the passage of several bond issues to purchase property and/or construct homes and day program sites, as well as state general revenue to fund services. Access to federal funding through the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program provided the financial support for operation of residential and day programs. This was by its nature a medical-based model for long-term care that included significant regulation and oversight to ensure that individuals had access to quality services. Rhode Island was again the leader as the first state to obtain approval for the use of federal ICF/MR funding for residential settings of six persons or less, and the first group home was opened in 1975. A statewide zoning law was enacted in 1977 which compelled local communities to accept community residences for six or fewer unrelated individuals as a single family home.

*The parents movement influenced local politics as well. The successful passage of bond issues for services for the retarded, and the legislative*

*establishment of the Office of Mental Retardation are examples of the influence of the parents on state policy.*

-Rhode Island History, Days of Darkness Days of Hope, The Care of Mentally Disabled People

Despite all of the support, the population at Ladd Center was still very high, over 1,000 people in 1975, and the environment had not significantly improved. In 1975 *The Providence Journal* exposed the conditions at Ladd Center in a provocative series of articles. In 1977 a class action lawsuit was filed by the Ladd Center Parents Association, *Iasimone vs. Garrahy et al.* A *Stipulation Agreement* was signed in 1982 with a plan to move people into the community. This led to the most successful deinstitutionalization process in the country gaining national recognition because Rhode Island's deinstitutionalization plan incorporated the individuals who lived in the institution, the people who lived in the community who needed residential services, and the public employees at Ladd Center. As the community system grew over the years, it created community-based living arrangements not only for those individuals who were leaving the institution but also those in need of residential services in the community. In an unprecedented effort, Robert L. Carl, as Executive Director of the Division, Ladd Center leadership, and the AFSME labor union leadership for the workforce at Ladd Center, fashioned an agreement that there would be no job loss or layoffs as a result of the movement of individuals into the community. This Memorandum of Understanding was fundamental to the support of the unionized workforce of the deinstitutionalization process. The MOU and its provisions helped ensure a smooth, well-supported transition to community life for people who had been living at the Ladd Center. On July 30, 1986, the Governor held a press conference at Ladd Center, where he announced that Rhode Island would close its institution for the mentally retarded, making Rhode Island the first state to publicly declare its policy that it would close the state institution. Ladd Center officially closed in 1994, the third state in the nation to close its institution.

In order to expand services and create flexible options within the community-based system, the State applied for the Medicaid funded *Home and Community-Based Waiver*. The Waiver allowed the state the flexibility to expand services and access federal funding for Early Intervention Services, family support services (Homemaker, Respite, Specialized Medical Equipment, Adaptations to the Home), Semi-Independent Residential Services, and Shared Living Arrangements (also known as Adult Foster Care). Approved in 1982, The *Waiver* continues to be the main funding source for program services.

In 1987 the *Right to Service* legislation changed the eligibility criteria for individuals who could receive funding from the Division by incorporating the federal functional definition of "developmental disability." This broadened the population meeting the eligibility criteria from only individuals with mental retardation to also including individuals with developmental disabilities. As a result of the passage of the *Right to Service* legislation, a state general revenue appropriation was established which allowed individuals with developmental disabilities to request funding that they could receive directly to purchase services. Most significantly, this program made the concept of self-directed services a reality. This expansion in the scope of the population served by the Division led to the statutory name change from the Division of Retardation (DOR) to the Division of Retardation and Developmental Disabilities (DOR/DD); later to become the Division of Developmental Disabilities (DDD).

In 1991 Rhode Island became one of only eight states to receive a five-year grant from the Federal Government called the *Community Supported Living Arrangement (CSLA)* Program, a unique “limited option waiver”. The establishment of the federal CSLA limited option waiver can be linked to the work of Rhode Island Senator John Chaffee’s efforts in Congress, to stimulate creating thinking and create responsive changes in the Home and Community Based Waiver Program. This special waiver allowed the state to expand the opportunities for individuals to direct their services to anyone who was eligible for Division funded services. Very importantly, *CSLA* also introduced the concept of individualized funding. There were no contracts between the state and service provider agencies. Individualized Plans formed the agreements between the state and the person relying on supports. Individuals received the funding directly and could purchase the supports and services they needed. When this grant ended, the individuals were enrolled in the *Home and Community-Based Waiver*, and the concept of self-directed services was incorporated into the *Waiver*. To continue the spirit of self-direction and control of resources, the Waiver was amended to include the means for self-direction and management of their services through an intermediary service organization or “fiscal intermediary.” Over time, the *Waiver* was amended to include other services, such as Supported Employment and Personal Emergency Response Systems.

*There is a new way of thinking about how, where and with whom people with developmental disabilities can live, learn and work. This new way of thinking has involved a shift from a preoccupation with preparation, care and treatment to a concentration on supporting participation, building on capabilities, adapting environments and building relationships. The old way of thinking meant offering individuals and families a limited number of options. The new way of thinking means assisting individuals and families in identifying what is important to them, and empowering them with decision-making and spending authority to act upon those choices.*

- “A New Way of Thinking,” Governor’s Planning Council on Developmental Disabilities, MN

In 1994 Rhode Island submitted a Medicaid 1115 Waiver called *CHOICES (Citizenship, Health, Opportunities, Interdependence, Choices, Environments, Supports)*. This was a research and demonstration waiver as it incorporated more flexibility and personal control by the individual and family in the choice of their long-term care supports, and a managed care model to improve access to acute medical care for individuals with developmental disabilities. Rhode Island withdrew the five-year demonstration waiver application, in favor of incorporating the long-term care system change concepts of *CHOICES* into the Home and Community Based Waiver. These concepts became the basis for the evolution of services in Rhode Island.

A shift in thought and practice was necessary to create an environment that enabled individuals and families to make choices and direct their future. The emphasis needed to more clearly expand to include people and their friends and families in the decision-making, rather than the primary dialogue for contracted services occurring between the state and service providers. Person-centered planning and individualized funding was at the core of this shift, as initiated first under CSLA. Person-centered planning focuses on capacity thinking and looks toward a positive possible future, engaging the support of allies, considering community membership and contribution, and identifying all supports including needed services to reach goals that have been set. Individualized funding recognizes the funding as unique to the individual. The individual

receives information from the Division about the funding that will be available to the person to design and develop supports, and once funding is authorized, the individual is notified of the funding that the Division expects to spend, the types of services and supports selected by the individual, and the licensed and certified agency who will provide the supports. The individual may also choose to manage their own supports using the services of a Fiscal Intermediary as a conduit for the Medicaid *Waiver* funding.

Some of the existing processes needed to change to support this evolution. An assessment process is utilized; the Personal Capacities Inventory (PCI) and Situational Assessment are completed and a program level determined. From the 'program level' a level of funding is assigned. A Support Agreement was also developed that documents the discussions and conversations between the individual/family and service provider(s) chosen by the individual to provide support. It provides information regarding the expectations of the parties (the individual and the provider agency selected by the individual), health and safety concerns, and the means for continued communication. Once signed by both parties, this document is reviewed and approved by the Division and becomes the vehicle to authorize funding. In addition, the Division and the licensed and certified agencies developed a *Certification Document* that supports this shift in thinking and practice. It includes processes/practices such as the PCI, Support Agreement, movement to individualized funding and the fundamental values at the foundation of the approach to supports and services for people with developmental disabilities who rely on the Division and its agents.

Rhode Island has always sought to improve the quality of its services. "In 1983, the Service Quality Network was established focusing dialogue and learning together around values common in all our lives: sharing places in community; making choices; developing valued competencies; building positive reputation and increasing status and valued roles; and community participation/building relationships." (Presentation by Parents and Friends for Alternative Living) In 1988, the first Facilitator's Forum was held. This forum provides opportunities for any interested stakeholder in the state to increase their skills and capacities in values-based problem-solving and creative thinking (described in "Implementing Person Centered Planning," O'Brien and O'Brien).

In 1998 legislation was passed prohibiting aversive procedures in the area of behavior management. This legislation, along with *Licensing Regulations*, became a catalyst for increasing the use of positive approaches in providing supports and assistance to individuals with developmental disabilities.

Throughout the 1980's and 1990's people from The Netherlands, Japan, the United Kingdom, Germany, Belgium and Australia visited Rhode Island to learn of its deinstitutionalization process and the building of its community-based system. A long-term partnership was developed with staff from the Netherlands, coordinated by Ms. Lynda Kahn. These visits became a kind of "external review process", creating an opportunity for the DD service network to look at its own programs and services through the eyes of another...an opportunity for review and growth. This international exchange initiative stimulated dialogue that strengthened coherency with value and mission, and focused efforts to support and celebrate community membership for people with disabilities.

In 1984 Parents and Friends for Alternative Living (PAL) was incorporated providing advocacy and support for families. Self advocates organized as the Rhode Island Coalition of Self Advocates and in 1996 incorporated as “Advocates in Action.” Both groups developed a partnership for advocacy for individuals with developmental disabilities and their families. The self-advocates sent delegations to National Self-Advocacy Conferences and in 2000, Advocates in Action and PAL hosted the national “Ride the Wave” self advocacy conference in Rhode Island. Advocates in Action provide leadership training opportunities, offer information about the adult service system to students who are graduating from school, testify at hearings before the State Legislature, listen to individuals who are receiving services and help them to advocate for themselves.

*Thirty-five years ago parents revolted and protested the neglect and exclusion of their children with mental retardation. The most significant progress since that time has been the emergence of individuals with mental retardation as persons in their own right, as fellow human beings claiming their place in our society.*

-Gunnar Dybwad, 1985

The attached chart (Attachment A) displays the evolution in services, supports, and service delivery approaches over the past 50 years. All of the stakeholders in the DD network in Rhode Island continue to have the shared vision of providing opportunities and choices so that individuals with developmental disabilities can have full participation in community life. We must remember where we have been and what we have learned so that we will never regress. We must continue to listen to individuals with developmental disabilities and their families, challenge each other, “push the envelope,” and find new resources and partnerships that will support people to lead integrated and connected lives in their communities. We continue to strive for genuine *community membership vs. community presence*. John O’Brien

*Our goal should be clear. We are seeking nothing less than a life surrounded by the richness and diversity of community. A collective life. A common life. **An Everyday Life.** A powerful life that gains its joy from the creativity and connectedness that comes when we join in association as citizens to create an inclusive world.*

-John McKnight

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MHRH/DDD: 10/2006

## *Current Snapshot*

The Division of Developmental Disabilities' statutory requirement, through RI General Law 40.1-21-2, is to plan, develop, coordinate and administer a complete, comprehensive and integrated program for adults with developmental disabilities. Individuals receiving services in the developmental disabilities system have the opportunity to choose services that best meet their needs, and support their capacity to live in their homes in the community. The Division's fundamental goal is to support individuals in genuinely taking more personal control over their own lives, and to build and enhance meaningful community membership.

In carrying out this mission, the Division of Developmental Disabilities upholds these principles:

- Each individual is unique; supports and services shall be responsive to the individual and his/her particular situation;
- All of us develop and grow within a community of relationships; supports and services shall be designed to help build relationships;
- Each individual is deserving of respect; the Division strives to meet the highest standards of personal and professional integrity.

The eligibility criteria for DDD services is included in RI General Laws 40.1-21-4.3 and is as follows:

*(1) "Mentally retarded developmentally disabled adult" shall mean a person eighteen (18) years old or older and not under the jurisdiction of the Department of Children, Youth and Families, with significant sub-average, general intellectual functioning two standard deviations below the norm, existing concurrently with deficits in adaptive behavior and manifested during the developmental period. For purposes of funding, it is understood that students enrolled in school will continue to receive education from their local education authority in accordance with 16-24-1 et seq.*

*(2) "Developmentally disabled adult" shall mean a person, eighteen (18) years old or older and not under the jurisdiction of the Department of Children, Youth and Families, who is either a mentally retarded developmentally disabled adult or is a person with a severe, chronic disability which;*

- (a) is attributable to a mental or physical impairment or combination of mental and physical impairments;*
- (b) is manifested before the person attains age 22;*
- (c) is likely to continue indefinitely;*
- (d) results in substantial functional limitation in three or more of the following areas of major life activity:*
  - (i) self care*
  - (ii) receptive and expressive language,*
  - (iii) learning*
  - (iv) mobility*

- (v) *self-direction*
  - (vi) *capacity for independent living,*
  - (vii) *economic self-sufficiency; and*
- (e) *reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated. For purposes of funding, it is understood that students enrolled in school will continue to receive education from their local education authority in accordance with 16-24-1 et, seq.*

Attachment B is included which describes the support structure necessary for the Division to carry out its statutory requirements. It also describes the organization by functional area and the distribution of positions.



## ***Services Provided to Population***

A critical point to be understood about this service system is that the services are life-long. Services are described within three general categories of service. Residential services and family supports are mutually exclusive. The categories of Service are:

Residential Services,  
Day/Employment Services, and  
Family Support

### Residential Services:

Residential services include periodic support to assist an individual to live in the community (non-24 hour), supports whenever the individual is in the home (including overnight support), and Shared Living Arrangements (also known as Adult Foster Care). Requests for residential services are prioritized based on criteria from the *King* court case into three categories:

- **Priority 1** which means that there is a critical need for residential services immediately or within six months (i.e. individuals in medical and psychiatric hospitals, individuals who have turned 21 and are in an under-21 residential setting, situations of abuse, neglect or mistreatment, etc.). There are 150 individuals on this list.
- **Priority 2** which means that there is no critical need at the current time, but it is important to track these individuals due to the age or health care needs of the individual or primary caregiver (i.e. single parent, aged caregiver, caregiver who is ill, etc.). There are 87 individuals on this list.
- **Priority 3** which means that the individual/family has requested a residential service, but there is no immediately need for services. There are 63 individuals on this list.

### Day/Employment Services:

Day/employment services include a broad range of supports based on each individual's abilities and interests including, but not limited to: personal skill development, health and life education, socialization, prevocational services, community integration, volunteer opportunities, supported employment, and transportation. These services usually occur Monday through Friday, during the day; however, as individuals become more involved in the choice in services, some individuals are using their funding in a more non-traditional way (i.e. employment supports for second/third shift, community integration activities, etc.)

### Family Support:

The Division's focus is to support families so that their son or daughter can remain in the family home for as long as possible. Supports can include, but not be limited to: in-home supports, community integration activities, respite, homemaker/home health aide services, assistive technology, home modifications, and Parent Subsidy.

### Program Eligibility:

All individuals are eligible to be funded for day/employment services; however, in order to receive most residential services or family support, the individual must be eligible for the Home and Community-Based Waiver.

### Where people live:

Approximately 2,416 individuals do not live with their family. They live alone, with others with developmental disabilities, with others who do not have a disability, in nursing homes, shelter care facilities and in out-of-state schools. Some are homeless. 1,757 individuals live with their family.

### Residential Settings:

- 1,628 individuals (67%) receive 24-hour services funded by the Division. They receive services from private agencies and RICLAS.
- 45% of the individuals who receive 24-hour supports are aged 50+. These individuals are facing the same health care issues as the general population, and some individuals have a more vulnerable health status due to their disabilities.
- 68% of the individuals supported by RICLAS are aged 50+. This has a significant impact on RICLAS Medicaid revenue as there is a higher mortality rate (resulting in vacancies), more individuals are in hospitals (services cannot be billed to Medicaid), and overall the individuals need more support with medical issues as they age (there is no ability to increase FTE's and RICLAS currently does not have sufficient Community Living Aide FTE's to meet minimum staffing requirements).

### Family Settings:

- Approximately 550 individuals are aged 40+. By conservatively adding 20 years to the age of the individual with developmental disabilities, 29% of the people in the adult caseload who live at home live with caregivers who are over 60 years old.
- This statistic is significant as there will be a **strong demand** from these families for residential services in the coming years.

### **Providers**

There are 36 licensed agencies providing supports to eligible individuals. All agencies are also certified by the Division. There is one publicly operated provider and the remainder are private agencies.

Most agencies provide residential services, day/employment services and family supports. Some agencies provide only one or two categories of service.

## **Contracting process**

The Division does not enter into contracts with individuals or provider agencies. The *Certification Document* identifies the Division's program and financial requirements of the agencies. The Licensing Regulations stipulate other provisions that the agency must follow.

The Division has shifted the service system from one where the major service relationship was between the Division and the provider, to one where the major service relationship is between the individual and the agency chosen by the individual. The current process is described below.

Once an individual is determined eligible, a Social Worker is assigned. For newly eligible individuals and individuals requiring a new category of service or change in their current services, the following process is used. The Social Worker or agency currently providing services meets with the individual and those who know him/her best to complete a Personal Capacities Inventory (PCI) and a Situational Assessment (SA).

Division decisions to make funding available for the purchase of service in one or more of the categories of service are based on the existing need of the individual and/or the Individual's family/support system. Information sources for these decisions include:

- Application for Services
- Assessment Tools (Personal Capacities Inventory and Situational Assessment)
- Conversations with the Social Worker and other staff in the Social Services Unit
- Other evaluations/assessments as appropriate/available

The Division will make a determination as to the support level needed by the individual in each category of service requested, based on similarly situated individuals currently receiving services. The support level corresponds to a funding amount that the Division will make available to the individual to purchase supports. The individual is notified of their available funding and can use this letter in discussions with provider agencies. They negotiate the supports that they will receive and document their conversation on a Support Agreement. On a broad level, this document identifies the person's interests, the services that the agency will provide, the agency's expectations of the individual/family, any health and safety concerns, and the means of review services between the parties. In addition, the individual signs a form indicating that they have chosen the agency to provide services. The Support Agreement is reviewed by the Division and is the basis for funding to begin. Within 90 days of the authorization of services, an Individualized Plan is developed which is more detailed than the Support Agreement.

The individual can choose to manage their own supports, based on an Individualized Plan submitted to the Division for approval, using the services of a DDD Certified and MHRH licensed Fiscal Intermediary for the receipt and disbursement of funds.

## **Unmet needs for services**

The Division and the provider agencies attempt to meet each individual's need for support by developing services that the individual/family have requested based on the individual's capacities and interests. However, there are unmet service needs, or a delay in meeting service needs based on the following:

1. Insufficient residential settings to meet the needs of those individuals who have been identified as having a Priority 1 need for residential supports.
2. There can be a significant delay for individuals accessing day program services
3. Workforce issues, especially the ability to recruit and retain direct support staff.
4. Shortage of physicians, psychiatrists and dentists who will accept individuals with developmental disabilities
5. Shortage of routine preventative mental health services
6. Crisis services, hospital, diversion and hospital step-down
7. Emergency respite network
8. Supported Employment
9. Affordable, accessible housing/apartments
10. Knowledge about available technology to facilitate activities of daily living
11. While often eligible for DD services, the network of services is not really geared to the needs of individuals whose TBI occurred in the late teenage years. These individuals may better be served by the adult TBI network
12. Some individuals not eligible for DD services may "fall through the cracks" and need some level of support (i.e. Aspergers, some individuals with autism).
13. Coordinated approach to services for parents with developmental disabilities.

## ***Best Practice Discussion***

Rhode Island is in the interesting position of having a history of being on the cutting edge, but we have lost our momentum, and as a result, our leading status. For years, people would come from far and wide to see what Rhode Island was doing. It has been at least three years since we have hosted visitors from other countries, and with only few exceptions, from other states.

Different people attribute this change to different causes. Several internationally recognized DD experts have observed that the generosity of Rhode Islanders in making this one of the best funded service systems in the country has fueled our reliance on hourly staff and money to pay them as opposed to thinking creatively about other solutions and alternatives.

People in the Rhode Island service system would vehemently disagree with this observation, considering ourselves to have a long history of creative and out of the box thinking. These stakeholders would be more likely to point to the approach and attitude of the recent past MHRH administrations as stifling of innovation, and overly expectant of accountability, rules and regulations.

Some of us will acknowledge that we may have become complacent. We still think of ourselves as pioneers, and take great pride in being one of a minority of states that have closed their institution. It is not, however, something that we can point to indefinitely as evidence of our being in the forefront. Continuous change can become exhausting, particularly when so much effort and energy must be expended year after year to fend off proposed budget cuts to simply maintain the financial status quo.

Thus, our best practice section takes three parts:

- BEST PRACTICE currently happening in Rhode Island
- BEST PRACTICE historic to Rhode Island, but not happening much anymore
- BEST PRACTICE recognized as such nationally, but not currently happening on any great scale in Rhode Island.

### **BEST PRACTICE current to Rhode Island**

- There is a strong set of values that is shared by all stakeholders
- Strong self-advocacy network who are increasingly at the table, and listened to by other system stakeholders
- Comprehensive Leadership Training program run by and for Self Advocates
- Standardized assessment tools are used to determine a program support level for similarly situated people, yet allowing the flexibility to acknowledge individual support needs
- The opportunity for individuals to manage their own supports using a fiscal intermediary

- Use of a Support Agreement which documents the conversations and expectations between the individual/family and the agency selected by them. It also serves as the vehicle to authorize funding.
- Individuals and families can choose the agency (if the agency has the capacity at the time) to provide their supports
- There is a sharing of training resources among agencies. For example, the various RICLAS clinics and Special Care Facilities are available to the entire network of providers; agencies collaborate around training such as Human Rights, Medication Administration, Management Training, etc.
- Some individuals in the DD network of services have individualized funding which allows them to see and understand the funding available to them and how they choose to use these resources to meet their needs.
- The DDD staff is accessible and involved and knows individuals and families personally
- The program and fiscal staff within DDD communicate regularly with each other to foster and understanding of the support needs of the population served
- There is an excellent training program for direct support professionals
- Ongoing relationships with community organizations such as: Transition Councils, Hospice, the Alzheimer's Association, etc.

### **BEST PRACTICE historic to Rhode Island**

- The leadership of the Division had the authority to make decision, set standards, and work with the stakeholders to improve services for individuals with developmental disabilities.
- A “safe environment” where agencies worked with DDD to think creatively and experiment with new ideas/concepts/approaches, pilot them, and support each other through the process.
- Active and deliberate fostering of a climate that encourages new thinking and flexibility
- Organized efforts to share stories of success and inspiration, and celebrate accomplishments of individuals supported.
- Strong emphasis and dedicated resources to promote supported employment.
- Ability to reconfigure resources to fund new approaches and pilot programs.
- Ability to fund programs and services appropriately which allowed agencies to be financially stable.
- Continuous discussions with stakeholders resulting in changes in the structure of the DD system to support new ideas and approaches to service delivery.
- Development of new DD agencies that were supported by the larger DD agencies in order to improve access to services. Having both small and larger agencies offers the best of both approaches.
- External reviews by DD professionals from other states and other countries stimulated dialogue that strengthened Rhode Island's value and mission, and its focused efforts to support community membership for people with disabilities.

**BEST PRACTICE recognized Nationally,  
but not happening in RI on any sort of a large scale**

- Closure of sheltered workshops
- Incentives for supported employment over segregated settings
- Policy that expects the pursuit and maintenance of employment for all working age adults with developmental disabilities
- Portability of budgets
- Ability to pay stipends to co-workers and neighbors for agreed upon natural support
- Bottom-line budgets that enable flexibility across life-areas
- External case management and support coordination (Individual Plan facilitation and monitoring) for individuals receiving residential services from agencies
- Reserving some state only funds enabling more flexible programs that may not be possible under waiver assurances
- Use of technology to enable individuals to spend more time alone
- Citizen advocacy programs
- End-user accountability (resources enabling individuals receiving services to be the party to whom providers are accountable to, rather than a state bureaucracy)

## *Initial Findings*

Over the course of the past month and a half, we have met with various stakeholders of the work accomplished through the Division of Developmental Disabilities. Participants have included all segments of the DDD staff, written comments, as well as four community meetings, representing people served, families, community service providers and advocates. Our questions have focused on those suggested in the departmental letter to the community in late August: What does DD do well? Where is there need for more? How is the population changing? and What resources are needed? We have chronicled all feedback, even when veering from identified inquiries. We have compiled notes from each meeting, organizing emerging trends and common themes. With over 35 full flipchart sheets and over 55 pages of written notes we have endeavored here to include all feedback.

In compiling our initial findings into a meaningful report, while honoring the volume of heart-felt input, we realized that the emerging issues could be categorized in three tiers: root concerns, concurrent structural or process issues, and then indicators of health or breakdown within the system. Using the analogy of a tree, root issues are identified as feedback offered in almost every encounter. Structural or “trunk concerns” indicate process or systemic items that are apparently a result of the root issues, and were presented as such in our encounters. And the health or disease of the “DD organism” is indicated by the abundance or lack of leaves/the fruit-bearing aspect of the tree, and most often relate to answers to the question, “Are DD services on the cutting edge?”

The most prevalent, or root concerns, expressed in our assessment were:

1. Communications
  2. Leadership
  3. Staffing
  4. The life-long nature of developmental disabilities, yet the need for linkages
- 
1. The struggle with insufficient communications, deteriorating relationships and mistrust within and outside DDD was apparent throughout every conversation. The resulting process challenges were reported as:
    - The severe lack of linkages and cooperative ventures among MHRH Divisions (Behavioral Health, access to Slater Hospital) and other state agencies (i.e. affordable and accessible housing, Elderly Affairs, RIPTA, RI Housing, Transition Councils, Departments of Education, Children Youth and Families, Health, Human Services)
    - Supporting up-to-date information technology to provide ease of electronic communication/data among parties; more use of trends analysis, cost-benefit analysis, and calculations of “social capital”
    - Delays in getting funding level information from DD; agencies not getting enough background information from social workers or people they support
    - A reported loss of vital technical assistance from the Office of Health Care; the Office is currently completely un-staffed.
    - The need for bi-lingual/interpreter resources in both written and verbal communications



One of the indicators of breakdown in communication was the loss of candid dialogue about successes and failures, such as through the Service Quality Network, the International Institute, etc., bringing stakeholders together for brainstorming and resource sharing.

Another suggestion is the use of technology to link stakeholders together.

Also, sparsely located DDD staff among the state grounds, hindering the opportunity for “spontaneous collaboration” and convenient access to co-workers/leadership.

An example of a positive indicator, consistently stated in several meetings, was the fact that when contacting DDD from the community, individuals and families report connecting with a person who is willing and able to help them. People report great satisfaction in the personal “heart” in the face-to-face, person-to-person communications with DD.

Regarding this assessment, participants expressed repeated gratitude for being asked to contribute to the process, and reported a desire to continue the dialogue with the department. One suggestion would be to distribute copies of the assessment/feedback shared at community meetings.

2. DDD leadership must be expanded and include strong, dedicated visionaries grounded in the principles specified in Attachment C "Our Common Ground". Summing up frequent commentary regarding leadership, one participant said, "The Division needs its own torch carrier." The resulting systemic concerns that emerge due to a perceived lack of leadership were:
  - A decision as to the role of RICLAS in the DD network of services and supports and once that decision is made, to provide the necessary resources so they are “right-sized” for their role.
  - DD staff operating “in the dark” without a perceived alliance with MHRH/DD leadership, as they have experienced in the past.
  - The State bureaucratic processes create obstacles for managers, e.g. transitioning to a new payment system for finance staff. The goal should be to simplify processes, build linkages for inter- and intra-departmental collaboration for efficiency and cost-effectiveness, but avoid an amalgamation of all human services into one giant, layered, complex human service department.
  - The state processes (processes both within and outside of the department) for the filling of vacancies result in a significant delay in filling necessary positions that enable the manager to meet service requirements and expectations.
  - Many decisions/processes are made outside of managers’ program area that significantly impacts their ability to meet their goals and objectives in a timely way.
  - Managers must be able to make decisions, set standards and have sufficient resources to accomplish their tasks.

One of the indicators of breakdown is the "hot button issue" of the Health and Wellness Standards, which significantly raise the scope and intensity of regulation related to healthcare and medication administration. Providers have also described a fear of risk-taking due to the climate resulting from a highly publicized series of investigations at one agency. The current environment seems increasingly reliant on regulation rather than providing sufficient resources at the state level for active monitoring. Said one participant, "The DD network always took the road that the person has the right to make choices and supported the person to make choices." It was okay for people to make decisions that involved risk, obviously within certain guidelines. "We shared the risk, and learned from mistakes together." Another person reported, "We are at a place where blame is the solution to the problem." The Office of Quality Assurance and Licensing should be re-directed to focus less on holding agencies accountable to regulations, and more on assisting agencies to make appropriate changes to be better organizations

There is also an erosion of advocacy at various levels, from legislative to grassroots.

One suggested and critical positive indicator is the need for a DD strategic plan, with a clear and articulated vision about the next phase in the evolution of services.

3. Sufficient and appropriate staff within DD as well as within provider agencies is the backbone of the service delivery system. Structurally, the quality of the service system depends on a strong foundation of direct support professionals. Indicators of structural decay were reported as:
  - Prolonged (up to a year or more) vacancies and uncertainty about frontline staff positions within DD, including Social Caseworkers and Direct Support Staff in RICLAS. DD Social Caseworkers have caseloads that include 140-170 people, in contrast to a national average of 50 among DDD systems in other states.
  - In the community, difficulty in recruiting and retaining the caliber of staff needed to provide quality services.
  - There was a strong need reported to professionalize the career path of direct support staff and pay them appropriately for their level of responsibility, including adequate benefits and regular cost of living increases.

Signs of strength that were suggested in our conversations include regular access to professional development opportunities and options for "growing in the job", staff longevity, and innovative management/leadership practices, such as self-directed work teams.

4. DD eligibility is life-long and the nature of this service means that supports to an individual are very likely to increase as circumstances change over time. DD cannot be treated the same way an acute medical condition can. Supports can be provided to allay the secondary effects of a disabling diagnosis, empowering an individual and family to fulfill their greatest potential to be a contributing member of their community. There is a need however to build carefully crafted linkages to other state and private networks to access additional expertise, share best practices, and provide the comprehensive support plan that the people DD supports need.
  - Individuals entering the service network are requiring increasingly complex and intensive therapeutic and clinical interventions and/or different approaches in

service delivery on a continuing basis (individuals involved with criminal justice system, transitioning from psychiatric hospitals, are dually diagnosed (DD/Mental Health), with Traumatic Brain Injury, with technology dependency, with Autism, with Asperger's Syndrome, non-English speaking individuals and families)

- As more services have been available to support children with disabilities in both the home and school setting, families have come to depend on that level of service and expect it to continue in the adult service system. Relationships with the Department of Education and Local Educational Agencies need to be cultivated to build better transitional planning and communications with families.
- As individuals age, their need for support often increases (i.e. loss of skills, medical issues, move from semi-independent supports to 24-hour supports). There are approximately 300 people awaiting residential options.
- Several hundred caregivers are also aging (approximately 550 primary caregivers over the age of 60), resulting in the need to increase supports to the family or placement outside of the family home (residential services). There is a strong need to implement other residential options (i.e. rent subsidies, Shared Living Arrangements).
- The lack of capacity within the DD network for crisis intervention to avoid more costly hospitalizations and step-down program from hospitals to avoid prolonged hospitalizations or nursing home placements
- The need for more and better transportation options,
- The need for accessible, affordable housing options,
- The restoration of capital and facilities funds, e.g. Access to Independence

Some indicators of breakdown in this area were the alienation of RICLAS from the other DD community providers. They are expected to operate similarly, but are “stuck” within the bureaucracy of the state system.

Similarly, RI ranks poorly in the area of supported employment for people with disabilities; though rather highly for people with behavioral health concerns. As one participant stated, “Community based employment is neither prioritized nor provided to the majority of working-age DDD customers. Based on current funding, a higher priority seems to be placed on non-employment day services and sheltered employment services.”

And, a term used in describing the situation that people with disabilities face as a result of incomplete linkages among state departments is “forced oppression”. People get the support to be safe in the community, but are unable to thrive. Rather than just “filling beds or slots, we need to support people.”

A sign of network strength may be indicated by better understanding/“marketing” about people with DD, and the services provided within the DD network to the greater community. And, perhaps a stronger alliance with the business community would be beneficial. Essentially, DDD provides investments in the citizen, with rippling returns to the community, e.g. social capital. One participant asked, “What it would cost without DD?”

Another positive indicator, apparent in RI, is the presence of strong self-advocacy groups.

Based on our conversations with DD staff, people and families served by the system, advocates, community providers, we offer the following summary of answers to the questions posed by the department:

- **What does DD do well?** The answers to this question were often provided in the past tense “We used to...”. The culture of experimenting with new approaches and services with people, families, and agencies, challenging each other, “pushing the envelope,” with a collaborative spirit have been denigrated over the past few years. However, the system remains rooted in a strong commitment and principles set forth over decades of service evolution. As one participant stated, “We have retreated to bunkers over the past few years. We have begun to peek out, and are hoping for an all-clear signal.” Within the community and DDD, from finance and administrative staff, to Program Review, facilities, quality assurance and social services, there was a strong alignment behind purpose and people. It appears critical to continue the work that has been started, and keep leading the system down the path of person/family-focused control and choices.
- **Where is there need for more?** This report covers myriad examples of need and setbacks in progress. However, it is our belief that initial and immediate focus on the root issues, improving communications, establishing visionary leadership, building a strong direct support foundation, and preserving DD uniqueness yet forming necessary linkages, will yield naturally emerging improvement in the more systemic and symptomatic concerns. One suggestion is to continue this dialogue with the community into the planning and implementation phase.
- **How is the population changing?** People and caregivers are aging...young families are coming up through an ever-evolving educational system, carrying forth similar expectations of DDD...as people experience less structured living options, some may encounter issues with criminal justice, substance abuse, etc...new diagnosis such as Asperger’s and Autism Spectrum are challenging traditional support approaches. DDD needs to remain flexible to meet the ever-changing needs of the people “knocking on the DD door”. And, DDD needs to remain responsive to the changing needs of the people already inside.
- **What resources are needed?** Again, examples of needed resources are generously presented throughout this document, offered by the various stakeholders who participated in the process. However, we believe that focusing efforts to relieve the root issues, communications, leadership, staff resources and linkages, the indicated structural concerns and symptomatic indicators will have the nurtured base from which to address needed resources.

Just as a tree requires strong roots to deliver nourishment through the conduit of its trunk and into the leaves and fruit-bearing parts, so does the network need grounding in a communicated, common vision, beliefs and shared practice. With strong roots, the network can weather heavy storms, evolve to meet changing climates, and provide bounty to the community. Powerfully yet simply stated by one participant who receives support through DDD told us,

*“All I want is to contribute to and be valued by my community.”*

The Rhode Island Department of Mental Health, Retardation and Hospitals  
ATTACHMENT A

## THE EVOLUTION OF SERVICES AND SUPPORTS

<b>Focal Questions</b>	<b>Era of Institutionalization 1869-1960</b>	<b>Era of Deinstitutionalization 1960-1990</b>	<b>Era of Community Membership 1990-Present</b>
Who is the Person of concern?	The patient	The client	The citizen/consumer
What is the typical setting?	An institution	A group home, workshop special school, or classroom	A person's home, local business, neighborhood school
How are the services organized?	In facilities	In a continuum of options	Through a unique array of supports tailored to the individual
What is the model?	Custodial/Medical	Developmental/behavioral	Individual and family support
What are the services?	Care	Programs	Accommodations, supports, personal assistance
How are the services planned?	Through a plan of care	Through an individualized habilitation plan	Through an individualized support plan based on individual, family and community capacities
Who controls the planning decisions?	A professional (usually an MD)	An interdisciplinary team	The individual, with necessary supports for decision-making
What is the planning context?	Standards of professional practice	Team consensus	A circle of support
What has the highest priority?	Basic needs	Skill development, behavior management	Choices, personnel preferences, relationships/ connections, and contribution by the individual
What is the objective?	Control of care	To change behavior	To change the environment and attitudes in order to increase opportunities

Human Service Research Institute, V. Bradley, 1986. Adapted by MHRH 2002

July, 2002

## *ATTACHMENT B*

### DIVISION STRUCTURE

To fulfill the Division requirements, it needs a structure that:

- ❑ responds to individuals that apply for services in a timely way,
- ❑ assists individuals in negotiating the service system, assesses the individual and family's need for support, provides case management services and crisis intervention services,
- ❑ has the ability to make judgments of clinical necessity and clinical appropriateness for the services being requested,
- ❑ has the ability to make judgments regarding the level of support an individual requires based on similarly situated individuals,
- ❑ authorizes services for individuals in a timely way,
- ❑ supports individuals in having a voice in the determination of the supports to be provided,
- ❑ responds to individuals with developmental disabilities and their families as their needs change,
- ❑ provides opportunities to develop creative options in meeting individual's needs,
- ❑ ensures the most effective use of resources,
- ❑ ensures that our processes, policies, practices and agreements are respectful and as person-centered and directed as possible,
- ❑ ensures individual satisfaction with the supports received and related quality outcomes,
- ❑ provides for quality assurance and quality improvements in service delivery,
- ❑ promotes the health of the individuals and their access to the acute care system,
- ❑ monitors the medical services provided to individuals who have complex medical diagnoses,
- ❑ certifies new agencies who apply to be providers of service in Rhode Island,
- ❑ provides the ability to upgrade and modify existing technology to meet the needs of funding sources, staff, management, etc.,
- ❑ monitors service provision for all individuals receiving services,
- ❑ ensures that individuals receiving supports in day and residential settings have facilities that meet health, fire and life safety standards,
- ❑ maintains Medicaid and Waiver compliance, and
- ❑ updates payment and other record systems per HIPAA.

In FY 2007, the Division has total full-time equivalent (FTE) positions of 598. This is divided between the central office/private operated services (74 FTE) and RICLAS (524 FTE). The Division is administered by an Executive Director's office (3 FTE) and is divided into functional areas that include:

- Eligibility,
- Agency Certification,
- Services and Resource Development,

- Service Coordination/Case Management,
- Health Care,
- Quality Assurance, and
- Fiscal Management
- RICLAS (Rhode Island Community Living and Supports)

RICLAS is considered a provider of service and represents the publicly operated program for individuals with developmental disabilities.

#### ELIGIBILITY:

Approximately 180-200 individuals with developmental disabilities apply for services each year. The primary referral source is the individual with developmental disabilities' family (45%).

The application is reviewed by a clinical team of DD staff including: a psychologist, nurse, social worker, social casework supervisor, administrator, and any other clinician that the team feels is necessary in order to make an eligibility determination. The eligibility determination is made based on the promulgated *Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult*, dated January, 2002. Approximately 10%-15% of applications are clear cut as to eligible/not eligible. The remaining 70% require significant clinical review and data in order to make the determination.

Approximately 80% of these individuals are determined eligible for Division funded services, based on the above criteria.

There are four FTE assigned to this function.

#### AGENCY CERTIFICATION:

Any agency that wishes to provide services funded by the Division must apply for Division Certification. Staff from the Division review the application and a site visit may be made to programs operated by this agency in Rhode Island or another state. Once the Division agrees to certify the agency, the agency must sign a *Certification Document* that indicates their agreement to comply with the Division's program and financial requirements. The agency must then be licensed by the Department.

There are approximately six staff that participate in this function.

#### SERVICES AND RESOURCE DEVELOPMENT:

Staff work collaboratively with agencies, individuals, families, and advocates to develop systems of support and information for those seeking and using services. They also rate assessment tools, notify individuals of the funding available to them, make programmatic recommendations regarding requests for services at an administrative level, assist in the development of residential options, assure fire and life safety compliance, and provide technical assistance to improve

quality of services. The Access to Independence Program is administered by staff in partnership with RI Housing.

While there are five FTE's assigned to this function, this is a component part of every person's job responsibility in the Division.

#### SERVICE COORDINATION/CASE MANAGEMENT:

All individuals eligible for Division funded services are assigned a Social Worker in the Division's Social Services Unit. The Social Worker guides the individual and their family through the service system; makes recommendations on service requests, authorizes some services, and monitors services as required by the Home and Community-Based Waiver; provides crisis intervention support; and provides assistance to them throughout their lives. In addition, the Social Worker completes assessment tools. These tools are rated and form the basis for the funding that the individual can receive to purchase supports.

In addition to the above, this office coordinates residential services. The Social Services Unit identifies individuals in critical need for residential supports, collaborates with other Division staff and agencies to develop new residential programs, matches individuals with similar needs, and coordinates referrals of individuals to fill residential vacancies.

This office also completes evaluations of individuals with developmental disabilities in nursing homes, and offers day program supports should the individual request them per PASARR regulations.

There are 42 FTE's assigned to this unit including Social Workers, Casework Supervisors, clerical and administrative staff. The average caseload per Social Worker is approximately 150. National standards suggest caseload averages of 40-50. Some New England states have worker to consumer ratios at this level or lower.

#### HEALTH CARE:

The Division's Office of Health Care establishes policies to promote best practices for health care related long-term supports, reviews individual plans that include significant health care supports and make recommendations, provides technical assistance to individuals with disabilities, family members, and agency staff, provides oversight of the implementation of the *DDD Health and Wellness Standards*, and tracks mortality statistics.

There are two FTE assigned to this function.

#### QUALITY ASSURANCE:

The Office of Quality Assurance was established through legislation. This office establishes reporting requirements for instances of abuse, neglect or mistreatment, and provides training and technical assistance to agencies. Staff are involved in bi-weekly Incident Management Reviews and follow-up, and they investigate reported incidents of significant abuse, neglect,



mistreatment. This office works collaboratively with the Office of the Attorney General, Sexual Assault and Trauma Resource Center and local police.

There are nine FTE assigned to this function

FISCAL MANAGEMENT:

This office provides all financial management functions for the Division. This includes the developing the budget, monitoring and projecting of expenditures, processing of payments, maintaining accounting records, authorizing services, collecting attendance information for all services, monitoring of enrollment and expenditure caps of the Home and Community-Based Waiver, participating in the monitoring of agencies, and providing technical assistance to staff of the Division and private agencies.

There are nine FTE assigned to this function.

# ***ATTACHMENT C***

## ***“OUR COMMON GROUND”***

- It is important that there be equity and fairness in our system.
- Our capacity to accommodate new people coming into the service system without waiting lists is highly desirable to maintain.
- We are personally and publicly accountable to people with disabilities and their families, the citizens of this state, and to one another.
- The system belongs to all of us – and all means ALL.
- We value our partnership.
- We have built the extraordinary accomplishments of supports and systems for people with disabilities through our collaboration.
- We need to work together with respect and civility.
- It is important to us that there is security and stability for people, including those people we serve and those who support and assist them.
- Direct service staff should have a good working wage to ensure continuity, stability and quality in support for people.
- It is important that there be continued investment and responsible management of growth and stability in the system for people with disabilities.
- Fiscal solvency of provider agencies is important to the continuity and stability of supports provided to people.
- Predictable cash flow helps support stability and fiscal solvency. Monthly payments in twelfths are desirable over per diem/attendance payment structures.
- It is important to ensure, as we have in the past, that we will take care of individual people with extraordinary or emergency needs.
- We are focusing on the shift to increasing control to people with disabilities and their families
- Our practice and policy need to support the above-referenced shift and this requires new ways of thinking, including adaptive changes in our practice and organizational structures.

### ***GOALS***

*~responsive*

*~stable fiscal base*

*~competent, committed staff*

*~transition to CHOICES*

*~making the system more understandable to people*

*~gives income/fiscal predictability*

*~ensures systems accountability, security and stability*

*For the people we support*

*~well-funded*

*~well-managed*

“What we Agree On” discussion points  
*Transition/Stabilization*  
September 23, 1997

MHRH-DDD/Provider  
Discussions  
Revised October 31, 1997



# Section V: Eleanor Slater Hospital

## **BACKGROUND**

### **Eleanor Slater Hospital**

Eleanor Slater Hospital provides long term hospital care services that are licensed by the Department of Health (DOH), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The Eleanor Slater Hospital is a 495-bed public hospital. The hospital provides long-term care services with the support of acute medical services. The most critical and active service in our hospital is the 77 bed acute med-surgical unit. In addition to this, the hospital services chronic and persistently mentally compromised adults in the Adolf Meyer Building (96 beds) beds. By far the largest service of the hospital is our long-term care section with two locations totaling 302 beds.

The Eleanor Slater Hospital (ESH) is comprised of two (2) sites, the Cranston site with 306 beds, and the Zambarano unit site in Burrillville with 189. The Eleanor Slater Hospital (ESH) provides special programs for people who suffer from mental illness, and neurological disorders, as well as the serious heart, lung, kidney and other diseases associated with aging. Special inpatient assessment programs provide in-depth diagnostic evaluation of patients suffering from physically or mentally disabling conditions to determine ways to prevent the need for institutional care. The hospital is one of the state's leading clinical centers for geriatric care and is a training site for students preparing for careers in nursing, rehabilitative services, gerontology, pharmacy, laboratory technology, and hospital administration.

#### **Statutory History:**

Title 40.1 Chapter 3, of the Rhode Island General Laws and the Public laws of 1969, Chapter 134, Section 6a, includes provisions relating to the Eleanor Slater Hospital. Title 40.1 Chapter 3 of the Rhode Island General Laws includes provisions relative to Eleanor Slater Hospital - Zambarano Unit. Titles 40.1, 5.19, 21.30 and 21.31 of the Rhode Island General Laws includes provisions relative to the Central Pharmacy.

### **Eleanor Slater Hospital/Zambarano Unit**

The Zambarano Unit is an integral part of the Eleanor Slater Hospital. This unit bridges the service gap between acute hospital level care and nursing home care. This organizational model provides patients discharged from acute hospital care still requiring active treatment with an opportunity to access specialized services. The mission is to deliver to its patients a wide range of hospital programs and services aimed at answering the patient's individualized clinical requirements, promoting functional independence, improving quality of life and, when appropriate, supporting discharge to less restrictive community based settings. This unit meets the needs of the most challenging long-term care patients in our state and is an integral part of our hospital's medical long term care service system.

The criteria for admission to the Zambarano Unit emphasizes the need for continued hospitalization for patients who have physically disabling conditions such as cerebral vascular

disease, respiratory problems and neurological disorders which require extensive hospital intervention. Patients with degenerative diseases including Multiple Sclerosis, Muscular Dystrophy, Arthritis, Parkinson's disease, Emphysema and Alzheimer's disease are actively treated.

The Zambarano unit is a 189 bed, medical long-term care unit providing comprehensive medical services to patients throughout Rhode Island. The hospital directly operates its own power plant, sewage treatment system, grounds and maintenance, laundry, and all associated support functions for a freestanding community hospital.

The Zambarano Unit continues to support four group homes for 19 multi-handicapped and developmentally disabled persons utilizing hospital budget dollars.

### **Central Pharmacy Unit**

The Central Pharmacy Services Unit is responsible for providing clinical services; medication and medical/surgical supplies to all patient care areas within MHRH in a cost-effective manner, with emphasis on medication control and accountability. In addition to providing medication to an institutionalized patient population, medication is also provided to the community-based populations treated through the Community Mental Health Center network. This program is known as Community Medication Assistance Program. Through an agreement with thirteen (13) community-based pharmacies, medication is supplied by the Central Pharmacy and is dispensed by community pharmacies to this patient population. In addition, the Central Pharmacy provides non-legend medication and medical surgical supplies and services to approximately 56 group homes and 3 skilled nursing facilities for the developmentally disabled population served through the Division of Developmental Disabilities.

The Central Pharmacy Services Unit (CPSU) consists of a warehouse distribution center, known as the Central Pharmacy, and two institutional level pharmacies. In addition, the Central Pharmacy distributes medication in a bulk fashion to the Mental Health Clinic Pharmacies. Approximately 1900 clients receive medication through the Community Mental Health Medication Assistance Program. Pharmacy Services provides medication to patients within the Eleanor Slater Hospital and to Adult Psychiatric Patients discharged to less restrictive settings in the community. Pharmacy Services prepares and dispenses approximately 325,000 units of medication a year.

### **Statutory History:**

The Hospital's legal basis for program operations is Title 40, Chapter 3, Section 1.8, 913 and Public Laws of 1969, Chapter 134, Section 6A.

## History

- Only public hospital system in Rhode Island.
- Roots in role of the state as responsible entity for care of vulnerable populations.
- Current status as hospital level of care for persons with long term chronic medical and psychiatric illnesses.
- Operates as unified hospital system on two campuses – Cranston and Zambarano.
- Strong history of successful compliance with licensing agency (DOH) and accrediting agency (JCAHO).
- Positive presence in the hospital community as a resource for individuals with long term complex medical and psychiatric illnesses.

## Findings

- Admission and discharge planning for the Cranston campus is complicated by the lack of options within the community, particularly for persons with chronic psychiatric illness.
- Access to the special long term capabilities of the Cranston and Zambarano campuses require a clearer definition of types of patients and supports needed for the patients. Examples include: specialized equipment, rehabilitative services, etc.
- Utilization of physical space on the Cranston campus needs to be better integrated to achieve efficient staffing for all services.
- Needs to establish hospital department level accountability for budget and personnel management.

## Information Technology

- The Eleanor Slater Hospital on the Cranston and Zambarano campuses are significantly lagging in the ability to perform functions that are routinely becoming expectations of JCAHO accredited hospitals. There is almost no ability to transfer patient information electronically on either campus.

## Quality of Care

- Eleanor Slater Hospital continues to successfully receive accreditation from the Joint Commission. Clinical care from a nursing perspective appears to be acceptable given the measures reported from the quality improvement process.
- Physician oversight and peer review of physician practice could be strengthened.



### Laboratory and Pharmacy Services

- These support services have strengthened their operations through the introduction of computer technology to support local operations for the laboratory and order entry for the pharmacy.

### Going Forward

- 1) Clearly delineate the mission of the hospital to serve Rhode Islanders who require an extended length of stay in a hospital setting to manage their chronic medical and mental health illnesses. The goal of the hospital stay will be to provide these services necessary to assist the individual to return to their families and communities in a clinically appropriate time.
- 2) Initiate and complete an assessment of all patients on both the Cranston and Zambarano campuses to assure that patients are located in the most appropriate and least restrictive environment.
- 3) Establish a hospital zone on the Cranston campus, consolidating patient services in those buildings that are contiguous to the Regan building.
- 4) Establish the Cranston campus as the Center for Excellence for managing care for persons requiring continuing care for their psychiatric illness.
- 5) The Cranston campus will also maintain a capacity to serve patients with long term care needs to ventilator care, as well as persons needing assistance to stabilize chronic medical and psychiatric illnesses pending discharge to a lesser intensive care setting.
- 6) The Cranston campus should establish a unit of 20-25 beds as well as an ambulatory service that can serve as a setting for assessment, evaluation and stabilization for persons with developmental disabilities and persons with chronic psychiatric illnesses that are persons who are part of the MHRH caseload.
- 7) Establish the Zambarano campus as the Center for Excellence for persons requiring extended hospital stays because of their complex medical conditions, medical conditions with a co-morbidity of psychiatric illness; those with a history of brain or spinal cord injury.